State of California Department of Consumer Affairs

BOARD OF PSYCHOLOGY
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CALIFORNIA BOARD OF PSYCHOLOGY

SUPERVISED PROFESSIONAL EXPERIENCE VERIFICATION OF EXPERIENCE FORM

THIS FORM IS TO BE COMPLETED BY THE PRIMARY SUPERVISOR UPON COMPLETION OF THE SUPERVISED PROFESSIONAL EXPERIENCE. THE PRIMARY SUPERVISOR SHALL COMPLETE THIS FORM, ATTACH IT TO THE *SUPERVISION AGREEMENT FOR SUPERVISED PROFESSIONAL EXPERIENCE* OR TO THE *PLAN FOR ALTERNATIVE SUPERVISED PROFESSIONAL EXPERIENCE* (WHICHEVER PERTAINS) AND SEND THE DOCUMENTS DIRECTLY TO THE BOARD OF PSYCHOLOGY.

SUPERVISEE							
Name: Last	First	M.I.	AKAs/Aliases: Last	First	M.	Date of Birth:	
Email Address				Telephone Number			

PRIMARY SUPERVISOR						
Name: Last	First	M.I.	Telephone Number	Email Address		
Address: Street				City	Zip	
License Type			License Number	Issue Date	Jurisdiction (State or Province)	

ALL OF THE CONDITIONS AND ACKNOWLEDGEMENTS SET FORTH IN THE *SUPERVISION AGREEMENT FOR SUPERVISED PROFESSIONAL EXPERIENCE* WERE COMPLIED WITH BY THE SUPERVISEE AND MYSELF. Yes _____ No _____

THE ABOVE NAMED APPLICANT DEMONSTRATED PERFORMANCE AT OR ABOVE THE LEVEL OF MINIMAL COMPETENCE EXPECTED FOR THIS APPLICANT'S LEVEL OF TRAINING. Yes _____ No _____

# of hours worked per week	# of hours of supervision per week	Starting Date	Completion Date	# of hours being verified as meeting minimal competency expected.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT ALL THE FOREGOING IS TRUE AND CORRECT.

Primary Supervisor's Name: _____
(Print or Type)

Primary Supervisor's Signature_____

City/State _____

Date _____